DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

San Francisco Regional Office

Mr. Stan Rosenstein
Chief Deputy Director of Programs
California Department of Health Care Services
1501 Capitol Avenue, MS 0000
P.O. Box 997413
Sacramento, California 95899-7413

JUL 2 4 2008

Dear Mr. Rosenstein:

Enclosed is the Centers for Medicare & Medicaid Services' final Financial Management Review report # 09-FM-2005-CA-001-LTCSDU, entitled "California's Supplemental Reimbursement Program for Outpatient Hospital Services". We apologize for the delay in issuing the final report.

The primary objectives of the review were to determine that the initial supplemental payments claimed on the form CMS 64 are reasonable and allowable in accordance with the provisions of the state plan, and, whether hospitals receiving the payments are eligible to participate in the program. Our review covered expenditures claimed during the quarter ending September 30, 2004.

The final report incorporates the State's comments to the draft report and the CMS response to those comments.

We appreciate the assistance and cooperation that your staff extended to us during the review. If you or your staff have any questions regarding this report, please contact Tolu Oladimeji at (415) 744-3596.

Sincerely,

Gloria Nagle
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

cc: Tim Matsumoto, Chief, Provider Rate Section, CDHS, Suite 71.4001
Traci Walter, Audit Coordinator, Audits & Investigations, CDHS, Suite 120

FINAL

REPORT ON REVIEW OF CALIFORNIA SUPPLEMENTAL REIMBURSEMENT PROGRAM FOR OUTPATIENT HOSPITAL SERVICES

Control Number: 09-FM-2005-CA-001-LTCSDU

April, 2005

Review Performed by:
Centers for Medicare and Medicaid Services
San Francisco Regional Office
Division of Medicaid & Children's Health Operations
Financial Management Branch

EXECUTIVE SUMMARY

OBJECTIVE

Review outpatient hospital supplemental payments for California public providers for the quarter ending September 30, 2004 to determine: 1) if the initial supplemental payments claimed on the form CMS 64 are reasonable and allowable in accordance with the provisions of the state plan and 2) whether hospitals receiving the payments are eligible for the program.

BACKGROUND

Title XIX of the Social Security Act (the Act) authorizes the Federal Government to reimburse states for costs necessary to administer their Medicaid state plans. Outpatient reimbursement for hospital and clinic services must comply with regulations at 42 Code of Federal Regulations (CFR) Section 447.321. The California outpatient supplemental state plan amendment (SPA CA 02-018) was approved for supplemental reimbursement for an outpatient department of a general acute hospital. The SPA allows federal financial participation (FFP) for certified public expenditures (CPE) submitted by the State. The approved SPA states: The supplemental reimbursement under this program is available only for costs that are in excess of the payments the hospital receives per visit or per procedure for outpatient hospital services from any source of Medi-Cal reimbursement.

FINDINGS

The State included inpatient costs in the reimbursement calculation for five hospital facilities. The State made payments to several facilities that may not be governmentally operated. The State has limited controls to verify the governmentally operated status of facilities involved in the CPE process.

RECOMMENDATIONS

1. The State should make adjustments for overpayment and return excess payments to CMS.
2. The State should review the governmental status of each facility involved in the supplemental outpatient hospital reimbursement program.
3. The State should modify its methods and criteria to ensure that only governmentally operated providers are involved in the CPE process.

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INTRODUCTION

OBJECTIVE

Review outpatient hospital supplemental payments for California public providers for the quarter ending September 30, 2004 to determine: 1) if the initial supplemental payments claimed on the form CMS-64 are reasonable and allowable in accordance with the provisions of the state plan and 2) whether hospitals receiving the payments are eligible for the program.

BACKGROUND

Title XIX of the Social Security Act authorizes the Federal Government to reimburse states for costs necessary to administer their Medicaid state plans. Outpatient hospital and clinic services must comply with 42 CFR §447.321. The California outpatient supplemental state plan amendment (SPA 02-018) was approved for supplemental reimbursement for an outpatient department of a qualified general acute hospital. The SPA allows federal financial participation (FFP) to be provided as match for costs incurred by qualifying hospitals when serving Medicaid beneficiaries. Applicable costs of hospitals are identified via cost reports and are submitted as certified public expenditures (CPE) by hospitals to the State. Providers that are not eligible to certify public expenditures to the State under 42 CFR §433.51 would not be authorized to receive supplemental outpatient reimbursements. California's approved state plan states: The supplemental reimbursement under this program is available only for costs that are in excess of the payments a qualified hospital receives per visit or per procedure for outpatient hospital services from any source of Medi-Cal reimbursement. Aggregate Medi-Cal reimbursements provided to State government-owned or operated hospitals and non-state government-owned or operated facilities must not exceed the applicable upper payment limit (UPL) as determined under 42 CFR §447.321.

Section 1903. **(w)(6)(A)** of the Act specifies that the Secretary may not restrict states' use of funds where such funds are derived from state or local taxes or funds appropriated to state university teaching hospitals transferred from or certified by units of government within a State as the non-federal share of expenditures under this title, regardless of whether the *unit of government* is also a health care provider, except as provided in section 1902(a)(2), unless the transferred funds are derived by the *unit of government* from donations or taxes that would not otherwise be recognized as the non-federal share under this section.

In order for a health care provider to certify funds that are protected under Section 1903(w)(6)(A) of the Act, the health care provider must be part of a unit of state or local government. Furthermore, the CPE must be derived from state or local government tax revenues. Therefore, for a governmental health care provider to make a protected certification, it must have access to state or local tax revenues. Accessing state or local tax revenues means the provider must either have direct taxing authority or must be able to access funding as an integral part of a governmental unit with taxing authority. No contractual arrangement with the state or local government is necessary in order for the health care provider to receive tax revenues.

Section 1903. (w)(7)(G) defines the term "unit of local government" with respect to a State, as a city, county, special purpose district, or other governmental unit in the State. Regulations at 42 CFR 433.51 allow public funds to be considered as the state's share in claiming FFP if they meet the following conditions: The public funds are appropriated directly to the State or local Medicaid agency, or transferred from other public agencies (including Indian tribes) to the State or local agency or certified by the contributing public agency as representing expenditures eligible for FFP under this section. The public funds are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds.

METHODOLOGY

For this review, we looked at: 1) expenditures for FY 02/03 that the State claimed on the form CMS-64 for quarter ending September 30, 2004, 2) several Department of Health Services (DHS) policies and procedures, and 3) we held discussions with DHS staff. We read the instructions the State sent to the 70 hospital providers. We searched various Internet Sites for financial statement information, IRS certification, and government documents to substantiate the State's claim that the 70 providers paid are governmentally operated. units. We reviewed California's FY 2002/2003 expenditures of $90,445,446 for the Supplemental reimbursement program that was claimed during the quarter ending September 30, 2004. We reviewed the details (i.e. the actual invoices and invoice details) behind the CPEs. We selected a random sample of 20 hospitals from a total 70 hospitals the State had identified as public providers in its form CMS 64 submission for the quarter ending September 30, 2004. Additionally, the Audit and Investigations group (A&I) at the State audits all public providers annually. We limited our review to determining whether the State's outpatient supplemental hospital payments for California public providers followed the approved state plan and if hospitals receiving the payments are eligible for the program to determine appropriate reimbursement.

We conducted our fieldwork at the State's Rate Development Branch, Long Term Care System Development Unit (LTCSDU) offices in Sacramento, California from March 2005 to April 2005.

We assessed the following:

- Federal laws and regulations and Centers for Medicare and Medicaid Services guidance.
- The State's procedures for calculating supplemental reimbursement payments to its public providers.
- The State's procedures for determining the eligibility of its public providers.
- Supporting documentation from the State pertaining to the relevant reimbursements that were paid in September 2004.

We conducted interviews with:

- The State's DHS and LTCSDU personnel.
- The State's Chief, Field Operations Coastal Branch for Licensing and Certification Division (L&C) = Mr. T Scott Vivona.

FINDINGS

1. **The State included Inpatient costs in the reimbursement calculation for five hospitals.**

Inpatient Costs – During our review, we discovered that Inpatient Costs- (Lines 25 – 36 h of the Public Hospital Outpatient Services Supplemental Reimbursement worksheet) were included with the reimbursement calculation for five hospitals. This effectively increased the FFP amounts and resulted in overpayments to the five public providers. This accounting error has been explained to the State's DHS analyst that processed the payments. The State agreed that the necessary correction will be made. Additionally, the new package that will be mailed to public providers for FFY 03/04 supplemental reimbursement payments has been amended as required to avoid this accounting error.

On August 10, 2005, the State informed CMS that DHS had received all the overpayment from the five facilities and on August 15, 2005, the State further advised CMS that the refund will be included in the fourth quarter FFY 2005 MA claim which is due on September 30, 2005 (see attachments #1a & 1b). Total amount of refund to CMS was $149,563.49. No additional follow-up for this finding is necessary at this time.

State Comments

The CDHS concurs with these findings. Five of the 70 participating facilities incorrectly included inpatient costs in their reimbursement calculations. According to CDHS records, Fiscal Year (FY) 03/04 claim packets were distributed with a request for inpatient costs information. Because the final calculation included these costs, the federal financial participation (FFP) amounts were overstated which resulted in the overpayment of FFP to these facilities. CDHS took immediate corrective action to rectify this error. As a of the corrective action, all five hospital facilities have reimbursed the overpayment and the FFP was paid back to CMS.

CMS Response

The State concurred with this finding.

2. **The State made payments to 70 facilities under the O/P program, some of which may not be governmentally operated.**

The State made payments to several hospital facilities for the Outpatient Reimbursement Program that were classified by the Internal Revenue Service (IRS) as non-profit organizations under the Internal Revenue Code (IRC) section 501©(3). According to the Internal Revenue Service, a 501©(3) organization is defined as an organization that has been approved for recognition of exemption from federal income tax after filing **Form 1023,** *Application for Recognition of Exemption Under Section 501©(3) of the Internal Revenue Code.* In accordance with the regulation 501©(3), organizations are required to file an IRS Form 990, *Return of Organization Exempt from Income Tax.* In accordance with publication

557 of the IRS, organizations not required to file an IRS form 990 include a governmental unit or affiliates of governmental unit described in Revenue Procedures 95-48, 1995-2 B.418. We reviewed all 70 hospitals (see attachment # 2) that were identified as public providers by the State and found the following hospitals are recognized as 501©(3):

- El Camino Hospital
- Antelope Valley District Hospital
- Palm Drive Hospital
- Surprise Valley Health Care District
- Bear Valley Community Hospital
- Mendocino Coast District Hospital
- Oak Valley District Hospital
- Salinas Valley Memorial Hospital District
- San Gorgonio Memorial Hospital District
- Sierra Valley District Hospital
- Jerold Phelps Community Hospital
- Southern Inyo Hospital
- El Centro Regional Medical Center
- Eastern Plumas
- Corcoran District Hospital

We contacted t IRS and other relevant agencies for verification. Often, these facilities are not-for-profit facilities, which the State views as "public" based on the mission of the facility. However, these facilities may not be governmentally operated, as required under Medicaid law for purposes of CPE. This is not an all-inclusive list of facilities currently receiving supplemental outpatient hospital reimbursements that may not be governmentally operated. It is recommended that the State conduct a review of each individual facility to determine its governmentally operated status.

State Comments

The CDHS disagrees with this finding. In its explanation, the State outlined that Supplemental payments were made to the participating facilities based on the requirements outlined in the State Plan Amendment (SPA) 02-018, Supplemental Reimbursement program for Public Outpatient Hospital Services SAP 02-018 defines an eligible hospital as the following:

- Provides services to Medi-Cal beneficiaries
- Is an acute care hospital providing outpatient hospital services
- Is owned by a city, county, city and county, the University of California, or health care district.

The audit findings specifically listed 15 facilities as having an Internal Revenue Service classification that places their governmental status in question. CDHS has collected these 15 identified facilities' supporting documentation which establishes their governmental operated status. In accordance with the SPA's definition of an eligible participating hospital, CDHS believes the facilities met these requirements. These documents are available to the audit-

staff for verification.

CMS Response

CMS obtained and reviewed the State's analysis of the 15 identified facilities' supporting documentation which the State believes establishes their governmental operated status. We further reviewed the SPA's definition of an eligible participating hospital, and it's our opinion the documentation partially supports the current language in the State Plan, and it significantly differs from the explanation provided by the Grassley letter for a clear definition of a governmental agency. The Grassley letter states: "...for a governmental health care provider to make a protected transfer/certification, it must have access to state or local tax revenues. Accessing state or local tax revenues means that the provider must either have direct taxing authority or must be able to access funding as an integral part of a governmental unit with taxing authority." CMS also found that often, the State's supporting documentation shows these 15 facilities to be not-for-profit facilities, which the State views as "public" based on the mission of each facility.

Since no financial deferral was recommended, no further analysis is required at this time.

3. The State must expand its efforts in determining the governmentally operated status of facilities involved in the CPE process for purposes of outpatient hospital supplemental payments.

According to Section 1903 , **(w (6) (A)**of **(6)(A)** Act only "units of local government" are eligible to certify public expenditures. Section 1903(w) (7) (G) of the Act identifies five types of governments that may participate in the financing of the non-Federal share; States, cities, counties, special purpose districts, and other governmental units within the State. Accordingly, the State must identify the operational nature of each hospital that participates in this CPE process. The existing license controls may not ensure that only governmentally operated governmental providers receive the reimbursement payments. Our review found that for eligibility determination: the Long Term Care System Development Unit (LTCSDU) as a unit of the Department of Health Services (DHS), obtains an initial eligibility listing compiled by the Association of California Healthcare Districts (ACHD) and the California Association of Public Hospitals (CAPH) of all eligible hospitals. The lists provided by these member organizations are of facilities that are self-reported. Neither ACHD nor CAPH verifies that the reporting facility is a governmental facility as defined by Section 1903 **(w** of the Act. Our review discovered that in some instances, a facility may have declared to the State that it is a public entity because of its community based not-for-profit status. Moreover, the facility may not be eligible to receive or access tax revenues.

LTCSDU performs a couple of checks to verify the eligibility of its hospitals:

1) The primary check compares the initial listing to another similar listing found in the State procedures manual MR-ACL673-R001 – (see attachment # 3) that lists the required criteria from licensing and certification (L&C).
2) This final listing of eligible hospitals is then sent to the L&C department chief for further verification. The department chief parcels out the list to his representatives, who have to

verify that all hospitals within their coverage area are either public, county, or state owned or operated and still licensed to provide outpatient services. These representatives do not use the standards defined in the Act to determine that the hospitals are governmentally operated facilities. LTCSDU uses the verified final listing from L&C as its eligible hospitals that are paid under the approved outpatient supplemental SPA.

From our discussion with the State's licensing and certification department chief – (see attachment # 4), we discovered that the L&C does not consider the corporate structure of a hospital at any time when determining whether to issue a license to a provider. While the L&C reviews a wide range of standards when determining whether to issue a license to a provider, the L&C department chief, stated the corporate structure; for profit, non-profit, or governmental unit is not one of the items considered. Consequently indeed, several of the hospitals currently deemed eligible for supplemental outpatient hospital reimbursement appear to be merely "public" and not governmental in their operations.

While we recognize that there are non-governmental health care providers with an important purpose serving the public, a "public" orientation by itself does not qualify the provider to share in Medicaid financing. Governmental status is required to participate in the financing of Medicaid payments. Provider-related donations from non-governmental entities are impermissible under the Act.

It is recommended that the State modify its methods of identifying eligible hospitals for participation in the outpatient supplemental reimbursement program to ensure that only governmentally operated providers are using CPEs as required by the Act.

State Comments

The CDHS agrees with this finding. Previously, in the record of the CMS audit, the State's efforts in determining the governmentally operated status of facilities participating in the program, is based on a self-reported eligibility list from the hospital associations. CDHS then verifies the eligibility of each facility based on criteria from Licensing and Certification (L&C). The final eligibility list is then sent to L&C to further review a wide range of standards in determining whether to issue a license to a provider.

CDHS will revise its eligibility process to require eligible facilities to provide evidence of their governmental status. A copy of the governmental status will be maintained in each facility's folder.

CMS Response

The State concurred with this finding.

RECOMMENDATIONS

1. **Make adjustments to the overpayment for the hospital facilities.**

   While we identified five hospitals that included inpatient costs (total overpayment of $149,563.49), the State should review its payments to identify each facility that included inpatient costs in its reimbursement calculation. The State should perform its annual reconciliation of actual expenditures and payments to all facilities as outlined in the approved state plan amendment. Further, Federal Regulations at 42 CFR § 433.316 state that the State is obligated to return the excess payments to CMS within 60 days.

   State Comments

   The CDHS agrees with the recommendation to make adjustments to the overpayment for hospital facilities. To rectify this, CDHS will conduct a full review of each facility to identify entities that may have included inpatient costs in the reimbursement calculation. CDHS staff will then perform reconciliation reviews of actual expenditures and payments and begin the process to recover excess payments and return excess payments to CMS within 60 days after the conclusion of the reviews.

   As a result, additional measures will be made to review and identify facilities in subsequent years that have inadvertently reported inpatient costs information in error. Accordingly, action will be taken to correct any overpayments to the facility and refund FFP amounts as a result of the overpayment to these facilities.

   CMS Response

   The State concurred with this recommendation.

2. **Review the governmental status of each facility involved in the supplemental outpatient hospital reimbursement program.**

   Several of the hospitals involved in this program may not be governmentally operated. It is recommended that the State conduct a review of each individual facility to verify determine its governmentally operated status. Non-governmental facilities are prohibited from participating in the financing of the non-Federal share of Medicaid payments, eliminating the possibility of CPEs as a means of financing the non-Federal share.

   State Comments

CDHS concurs and will continue to comply with the recommendation to review the governmental status of each facility involved in the supplemental outpatient hospital reimbursement program. All eligible facilities were required to submit additional documentation to the CDHS by the end of July 2006. To date, all eligible participating facilities have contacted CDHS regarding the requested information and CDHS staff is currently in the process of reviewing and re-verifying each facility's status.

CMS Response

The State concurred with this recommendation.

3. **Ensure that criteria used to determine the governmental status of health care providers is consistent with the Social Security Act.**

The State should modify its methods and criteria for identifying eligible hospitals for participation in the outpatient supplemental reimbursement program to ensure that only governmentally operated providers are involved in CPEs as required by the CPE process.

State Comments

The CDHS agrees with this recommendation in regards to ensuring that the criteria used to determine the governmental status of health care providers is consistent with the Social Security Act. To ensure that the criteria used is consistent with the Social Security Act, CDHS will modify its method and criteria by requesting all facilities to provide the following information as evidence to the entities governmental status:

- Articles of Incorporation
- Certificate from the State Secretary of Treasury;
- IRS letter of 501(c)(3) status: or
- Resolution from Board of Supervisors, City or other government entity

This requested information will be used to verify the status of each participating facility claiming a "unit of government" as defined in 42 USC 1396b(w)(7)(G).

The documentation obtained from each participating facility will be maintained on the file with CDHS. This additional step will be in addition to the State licensing and certification review process.

CMS Response

The State concurred with this recommendation.
Additionally, CDHS can obtain and make available to CMS, information from its providers that shows the health care provider has access to state or local tax revenues. Accessing state or local tax revenues means that the provider must either have direct taxing authority or must be able to access funding as an integral part of a governmental unit with taxing authority: i.e. San Francisco General Hospital can be easily identified as

having direct access to tax revenues, since the provider is included in the San Francisco City and County's budget schedules with defined appropriations from the City tax revenues. The independently audited (by Ernest and Young auditors) financial statement verifies the same information.

CMS (RO) communicated this request to CDHS at the exit conference and will continue to work with the State on the same issue.

NOTES ON STATE'S RESPONSE

The State agreed with all findings except – CMS Findings 2.

The CDHS disagrees with CMS finding that: The State made payments to 70 facilities under the O/P program, some of which may not be governmentally operated. In its explanation, the State claimed that supplemental payments were made to the participating facilities based on the requirements outlined in the State Plan Amendment (SPA) 02-018. In its own research, the State provided supporting documentation which the State believes establishes the governmental operated status of the 15 identified facilities from our review. Though the documentation supports the current language in the State Plan, it however, significantly differs from the explanation provided by the Grassley letter.

Since no deferral was recommended, it's our opinion that no further analysis will be required.

Attachments

Oladimeji, Tolu (CMS)

From: Luxemberg, Rachel (DHS-MCPD-RDB-RDPRS) [RLuxembe@dhs.ca.gov]
Sent: Wednesday, August 10, 2005 9:55 AM
To: Oladimeji, Tolu (CMS)
Cc: Romero, Ruben (DHS-MCPD-RDB)
Subject: FW: In-Patient Hospital Costs - $149,563.

Hi Tolu-

The Department just received notice that all the money for the five facilities has been returned.

I should be receiving fax copies of EDS' Accounts Receivable, showing offsets today for the final two facilities.

Thanks,
Rachel

Rachel Luxemberg
Research Analyst II

California Department of Health Services
Medi-Cal Policy Division
LTC System Development Unit

Phone - (916) 552-9542
Fax - (916) 552-9660
rluxembe@dhs.ca.gov

-----Original Message-----
From: Romero, Ruben (DHS-MCPD)
Sent: Tuesday, May 17, 2005 3:31 PM
To: Luxemberg, Rachel (DHS-MCPD-RDB-RDPRS); 'Oladimeji, Tolu (CMS)'
Cc: Matsumoto, Tim (DHS-MCPD-RDB); Brennan, Willie (DHS)
Subject: RE: In-Patient Hospital Costs - $149,563.

Tolu:

Thank you for the update on these five facilities. Per your request, staff is in the process of notifying these facilities regarding the overpayment and how to repay the overpayment. Thanks.

-----Original Message-----
From: Luxemberg, Rachel (DHS-MCPD-RDB-RDPRS)
Sent: Tuesday, May 17, 2005 3:11 PM

Attachment 1a

To: 'Oladimeji, Tolu (CMS)'; Romero, Ruben (DHS-MCPD)
Subject: RE: In-Patient Hospital Costs - $149,563.

Tolu-
Did you mean to send this to Rick Romero? Or did you mean Ruben Romero?
Can you recall this message or has it been opened by that individual?

Rachel

-----Original Message-----
From: Oladimeji, Tolu (CMS) [mailto:TOLU.OLADIMEJI@CMS.HHS.GOV]
Sent: Tuesday, May 17, 2005 2:38 PM
To: Romero, Rick (DHS-MCH); Cody, Mary (DHS-IA); Luxemberg, Rachel (DHS-MCPD-RDB-RDPRS)
Cc: Brady, Timothy S. (CMS); Burdullis, Brian M. (CMS)
Subject: In-Patient Hospital Costs - $149,563.

Dear Mr. Romero,

During our Financial Management Review of California's Supplemental Reimbursement Program for Public Outpatient Hospital Services, we discovered that the State had improperly included $149,563 (FFP) of inpatient hospital costs in the reimbursement calculation for five hospital facilities. This error resulted in over payments to these five hospitals. The State needs to reduce its claim on the September 30, 2004 CMS-64 to remove these overpayments. We have provided your staff with the details for these five facilities.
We are continuing to work on other issues related to this review and hope to issue a draft report to the State in the near future. If you or your staff have any questions regarding this request, please contact me at (415) 744-3596 or at my email address: Tolu.Oladimeji@cms.hhs.gov. You may also contact Brian Burdullis at (916) 498-6523 or at his email address: Brian.Burdullis@cms.hhs.gov.

Sincerely,

Tolu Oladimeji

Attachment 16

Oladimeji, Tolu (CMS)

From: Marta, Gemma (DHS) [GMarta@dhs.ca.gov]
Sent: Monday, August 15, 2005 11:59 AM
To: Luxemberg, Rachel (DHS-MCPD-RDB-RDPRS); Cody, Mary (DHS-IA); Oladimeji, Tolu (CMS)
Cc: Tse, Ginger (DHS); Hirst, Starla (DHS)
Subject: RE: In-Patient Hospital Costs -CMS Review of Public Hospital Outpatient Services Supplemental Reimbursement Program

Hi, All. This adjustment should be included in 09/04qtr MA Claim which is due on 10/31/05. We will be able to show Tolu how we did the adjustment sometime the first week of November 2005.

Gemma Marta
DHS Accounting Section
Medi-Cal Accounting
Phone: (916) 552-8472
Fax: (916) 552-8538
mailto: gmarta@dhs.ca.gov <mailto:gmarta@dhs.ca.gov>

Attachment 16

CA OUTPATIENT SUPPLEMENTAL PAYMENT - (Review)

(Amounts are Federal Share, date of payment, FFY)
note: 1st payments made in Q4 2004

Hospital / *Fiscal Period*	Q4 2004 *FY 2003*	Not Unit of Government	Over Payment: In-Patient Costs
Alameda County Medical Center	$ 9,566,393.69		
Antelope Valley District Hospital	$ 1,684,345.46	NOT	$ 5,298.41
Arrowhead Regional Medical Center	$ 9,790,894.02		
Avalon Municipal Hospital	$ 51,855.17		
Bear Valley Community Hospital	$ 158,665.96	NOT	
Chowchilla District Memorial Hospital	$ 66,120.48		
Coalinga Regional Medical Center	$ 205,901.47		
Corcoran District Hospital	$ 110,175.52	NOT	
Eastern Plumas	$ 122,193.90	NOT	
El Camino Hospital	$ 583,898.25	NOT	$ 21,289.87
El Centro Regional Medical Center	$ 777,882.11	NOT	
Hazel Hawkins Memorial Hospital	$ 374,897.62		
Healdsburg District Hospital	$ 63,108.67		
Hemet Valley Medical Center	$ 202,485.11		
Hi-Desert Memorial Health Care District	$ 648,179.70		
Indian Valley District Hospital	$ 40,673.34		
Jerold Phelps Community Hospital	$ 12,354.91	NOT	
John C. Fremont Hospital District	$ 171,136.67		
Kaweah Delta Healthcare District Hospital	$ 909,142.49		$ 59,633.90
Kern Medical Center	$ 1,816,525.48		
Kern Valley Hospital	$ 146,939.45		
Kingsburg District Hospital	$ 79,104.16		
LAC, Harbor UCLA Medical Center	$ 3,358,246.36		
LAC, MLK/Drew Medical Center	$ 4,609,001.12		
LAC, USC Medical Center	$ 4,684,443.99		
LAC, Olive View - UCLA Medical Center	$ 2,108,988.42		
Lompoc Healthcare District	$ 15,423.02		
Mammoth Hospital	$ 63,381.79		
Mayers Memorial District Hospital	$ 231,921.40		
Mendocino Coast District Hospital	$ 419,769.61	NOT	
Menifee Valley Medical Center	$ 77,889.49		
Modoc Medical Center	$ 83,040.70		
Moreno Valley Community Hospital	$ 300,117.39		
Mountains Community Hospital	$ 292,126.94		
Natividad Medical Center	$ 1,374,921.29		
Northern Inyo Hospital District	$ 168,353.88		
Oak Valley Hospital District	$ 153,272.43	NOT	
Palm Drive Hospital	$ 64,482.86	NOT	
Palomar Medical Center	$ 484,932.18		
Pioneers Memorial Hospital	$ 1,027,423.43		$ -
Plumas District Hospital	$ 71,493.60		
Pomerado Hospital	$ 176,073.65		
Riverside County Regional Medical Center	$ 6,196,134.83		
Salinas Valley Memorial Hospital	$ 179,947.52	NOT	
San Francisco General Hospital	$ 2,428,248.13		
San Gorgonio Memorial Hospital	$ 126,342.77	NOT	
San Joaquin General Hospital	$ 1,502,126.05		
San Mateo Medical Center	$ 297,023.22		
Santa Clara Valley Medical Center	$ 5,238,102.32		
Santa Monica - UCLA Medical Center	$ 239,160.79		
Seneca Hospital	$ 92,747.53		
Sierra Kings District Hospital	$ 295,937.26		
Sierra Valley District Hospital	$ 25,055.21	NOT	
Sierra View District Hospital	$ 473,305.24		
Sonoma Valley Hospital	$ 184,430.08		
Southern Inyo Hospital	$ 33,508.78	NOT	
Surprise Valley Community Hospital	$ 12,122.79	NOT	
Tahoe Forest Hospital	$ 193,626.14		
Tehachapi Valley Healthcare District	$ 114,114.09		
Tri-City Medical Center	$ 664,171.80		
Trinity Hospital	$ 234,838.17		
Tulare District Hospital	$ 432,176.53		$ 21,141.51
Tuolumne General Hospital	$ 199,187.42		
UC Davis Medical Center	$ 5,240,886.12		
UC Irvine Medical Center	$ 714,610.39		
UC Los Angeles Medical Center	$ 3,640,218.96		$ 42,199.80
UC San Diego Medical Center	$ 5,249,701.32		
UC San Francisco Medical Center	$ 7,070,273.15		
Ventura County Medical Center	$ 1,527,281.74		
Washington Hospital	$ 501,990.38		
TOTAL	$ 90,455,445.91		$ 149,563.49
TOTAL REPORTED ON I-FORMS	$ 90,455,446.00		

Attachment #2

CALIFORNIA: Public Hospital Outpatient Services
Supplemental Reimbursement Process

This is a summary of the State's DHS policy:

The State follows various steps to process Supplemental reimbursements to its Public Hospitals for Outpatient Services. Outlined below are the steps:

Step 1: ELIGIBILITY DETERMINATION

Eligibility Determination: The Long Term Care System Development Unit (LTCSDU) – a unit of the Department of Health Services (DHS) within California, obtains an initial eligibility listing compiled by Association of California Healthcare Districts (ACHD) and California Association of Public Hospitals (CAPH) of all eligible hospitals. LTCSDU then performs a couple of checks to verify the eligibility of its hospitals:

1.) The primary check compares the initial listing to another similar listing found in MR-ACL673-R001 that lists the required criteria from Licensing and Certification (L&C).

2.) This final listing of eligible hospitals is then sent to Scott Vivona (L&C department) for further verification. Scott Vivona (the department chief) then parcels the list to his representatives, who then have to verify that all hospitals within their coverage area is either public, county, state owned and eligible or licensed to provide outpatient services. LTCSDU uses the verified final listing from L&C as its eligible hospitals.

Step 2: STATE'S DATA GATHERING

The State sends a letter to all eligible hospitals listed on the final listing from L&C, explaining to these hospital facilities that they can participate voluntarily in the supplemental reimbursement program. The letter outlines the program and its basic requirements. Each facility gets a packet directly from LTCSDU unit of DHS. Included in each packet are the following:

1. Claim and Certification form with instructions.
2. The Cost and Charge worksheet with instructions.
3. The Supplemental worksheet with instructions.
4. STD Payee Data Form with instructions.
5. The Agreement for participation.

Each hospital that wants to participate in the supplemental reimbursement program must have received a packet containing the audit schedules & instructions from LTCSDU. These facilities must ensure they send back to the State's Audit and Investigation department (A&I), a detailed schedule of the facility that captures their data from the cost and charge worksheet and the facility's supplemental reimbursement worksheet.

Additionally, each facility that intends to participate in the reimbursement program must return a completed packet to LTCSDU. Each packet from the participating hospital facility must include:

1.) An Agreement for participation which is the contract between the facility and DHS). This agreement must be on file for the first year and office of legal services (OLS) has informed DHS that this copy will suffice for all subsequent years.
2.) Claim and Certification.
3.) Cost and Charge worksheet.
4.) Supplemental reimbursement worksheet.
5.) STD 204 Payee Data Record – just for the initial year.

Step 3: STATE'S ADMINISTRATIVE FEE

The State's Administrative Fee component of the expenditures was contracted by CAPH to one of the eligible hospital facilities for the first reimbursement payment. CAPH got one of the eligible hospitals to volunteer to pay the annual administrative fee component and DHS sends the facility a separate agreement for this fee. This Administrative cost, the State defined as the cost of the one full time equivalent who performs the duties of this supplemental reimbursement program for the State.

The Administrative fee contract was set up by the contracts management unit (CMU) and DHS currently has Administrative Fee Agreement contracts signed with eight different facilities. It's our understanding that this fee stays with DHS.
Each Agreement contains the following segments:
1.) HAS 4827 – Incoming Funds request
2.) STD 215 - The Agreement Summary
3.) The DHS 2319 – Contract Request

Step 4: "STATE'S ONLY SERVICES"

For State only services: DHS obtains a State only services ad hoc report from its contractor - Electronic Data Services (EDS), this report provides facilities, outpatient Medi-Cal number and all other relevant information. The LTCSDU analyst sends to each eligible facility that participates in the supplemental reimbursement program, a copy of the Cost Report, Worksheet C, Part 1 for its reporting purposes. Each hospital uses its copy of the cost report to verify its numbers on the Cost and Charge worksheet.

Step 5: CLAIM PROCESSING

LTCSDU within DHS processes all supplemental reimbursement payments for outpatient services. LTCSDU starts the claim process by acknowledging receipt of returned packets from eligible facilities; a letter with the unit chief signature is sent to each facility indicating DHS has received its packet for participation. The individual facility agreements are then processed for participation by verifying actual cost and charge worksheet, supplemental reimbursement worksheet, and the claim and certification worksheet. LTCSDU uses the A & I copied cost report worksheet C, Part 1, for verification of costs submitted by each participating facility.

For State only services, LTCSDU ensures it reduces each facility's claim using the ad hoc report generated by EDS, if State only services are included with the costs from any eligible facility. An

email is also sent to the State's contact at the facility for this adjustment. The DHS analyst then updates all tracking charts, forms, and the control chart for payments to the eligible facilities. Prior to releasing the control charts, a secondary check of all numbers is performed with another analyst on all tracking charts and forms.

Step 6: SUPPLEMENTAL REIMBURSEMENT PAYMENTS.

The Payment process commences with an action notice to EDS for payment. The Package sent to EDS is signed off by the – Branch Chief and the documents of the package are faxed to EDS and also mailed to EDS. The package sent to EDS includes the following:

1.) Actions Notice Form
2.) A Chart listing facilities, Medi-Cal Outpatient Number, individual amount and the aggregate number on the Action Notice.
3.) A Chart with the address rooster of facilities to be paid.

Subsequently, EDS sends a letter notifying each facility receiving a payment, with a copy going to LTCSDU. EDS then sends each facility its supplemental reimbursement payment.

The Administrative Fee contract is processed by contract management unit. The LTCSDU analyst forwards a copy of the Admin Fee contract to DHS accounting with specific instructions to invoice the facility for the administrative fee component. It's our understanding that this fee stays with DHS.

Step 7: CMS 64 – REIMBURSEMENT CLAIMS ON CMS 64

After the payments are processed, the LTCSDU forwards to DHS accounting – the aggregate supplemental reimbursement amount and the quarterly breakdown paid to facilities for the FFY.

Luxemberg, Rachel (DHS-MCPD-RDB-RDPRS)

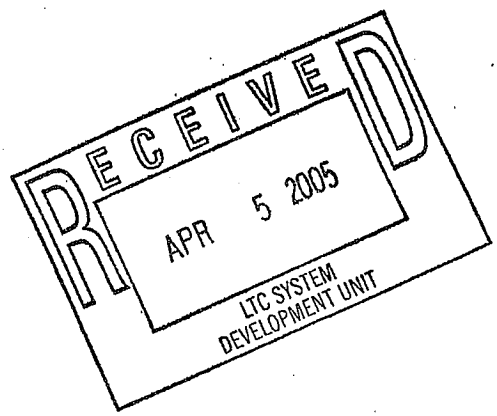
From: Vivona, Scott (DHS-L&C-FOBBAY)
Sent: Tuesday, April 05, 2005 12:02 PM
To: Luxemberg, Rachel (DHS-MCPD-RDB-RDPRS)
Cc: Creer, Eric (DHS-LNC); Vivona, Scott (DHS-L&C-FOBBAY)
Subject: RE: Some Hospitals may not be eligible to participate in the Public Hospital Outpatient Services Reimbursement Program (SFY 02-03)

I've attached the link http://www.cms.hhs.gov/manuals/107_som/som107ap_a_hospitals.pdf to the CMS website for the federal certification standards we use for certifying both new and recertifying existing hospital providers. The standards are found in Appendix A of the Federal State Operations Manual (SOM). Appendix A is over 300 pages…if your auditors don't wish to burn out a printer cartridge, they could call either Steve Chickering (who is the Acting Western Consortium Survey and Certification Officer for Survey and Certification at Region IX [415-744-3810]) or Deborah C. Romero (Acting Branch Manager for the Hospital and Community Care Branch at Region IX [415-7443713]) to get a copy of Appendix A.

L&C does not consider the corporate structure of a hospital when determining whether to issue a license to the provider. Having said that, for all new applicants, L&C checks to see if the provider or the corporate structure is in "good standing" as one determining factor to issue or not issue a license. (For example, if the owner/partner of the business had a fraud conviction, or the corporate entity has IRS liens etc., we may not issue a license.) However, we do not care about the corporate structure (for profit versus non-profit), when determining to issue a license.

In addition to what I said earlier, at the time the hospital submits an application to L&C, the hospital (if they wish to be certified) must submit a CMS Form 855 to the fiscal intermediary. The CMS 855 contains financial/corporate information. I don't really know what the fiscal intermediary does, but they may look more in depth at the corporate structure. In any case, L&C could issue a license to the new hospital but we would not conduct the federal certification survey until we had been notified by the fiscal intermediary that they had approved the CMS 855. Once we are notified of the approved 855, we would conduct the certification survey and survey to the standards in Appendix A. Assuming they pass the certification survey, we would process the survey findings to Region IX and the hospital could begin to bill for Medicare/Medicaid patients.

T. Scott Vivona
Chief, Field Operations Coastal Branch
Licensing and Certification Division
(916) 440-7377 (Fax) 916-552-8988
svivona@dhs.ca.gov



Attachment 4

State of California—Health and Human Services Agency

Department of Health Services

California Department of Health Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

OCT 2 - 2006

Ms. Linda Minamoto
Associate Regional Administrator
Centers for Medicare and Medicaid Services
Division of Medicaid and Children's Health
75 Hawthorne Street, Suite 408
San Francisco, CA 94105

Control Number: 09-FM-2005-CA-001-LTCSDU

Dear Ms. Minamoto:

This letter is in regards to the Centers for Medicare & Medicaid Services' (CMS) draft Financial Management Review entitled, "Report on Review of California Supplemental Reimbursement Program for Outpatient Hospital Services," dated June 26, 2006. Enclosed is the California Department of Health Services' (CDHS) response to the draft's content and recommendations.

The CDHS appreciates the work conducted by the CMS and the opportunity to respond to the draft report.

Should you have any questions, please contact Mr. Stan Rosenstein, Deputy Director, Medical Care Services, at (916) 440-7800.

Sincerely,

for Sandra Shewry
Director

Enclosure

cc: Mr. Stan Rosenstein
Deputy Director
Medical Care Services
1501 Capitol Avenue, MS 4000
P.O. Box 997413
Sacramento, CA 95899-7413

Attachment 5.

California Department of Health Services' Response to CMS on AB 915 Supplemental Reimbursement Program for Outpatient Hospital Services

The California Department of Health Services (CDHS) acknowledges recommendations provided by Centers for Medicare & Medicaid Services' (CMS) Financial Management Review report. This report highlights the following findings:

1. The State included inpatient costs in the reimbursement calculations for five hospital facilities;
2. The State made payments to 70 facilities under the Outpatient (O/P) Supplemental Reimbursement Program, some of which may not be governmentally operated; and
3. The State must expand its efforts in determining the governmentally operated status of facilities involved in the certified public expenditure (CPE) process for the purposes of outpatient hospital supplemental payments.

CMS Findings 1: The State included inpatient costs in the reimbursement calculations for five hospitals.

The CDHS concurs with these findings. Five of the 70 participating facilities incorrectly included inpatient costs in their reimbursement calculations. According to CDHS records, Fiscal Year (FY) 03/04 claim packets were distributed with a request for inpatient costs information. Because the final calculation included these costs, the federal financial participation (FFP) amounts were overstated which resulted in the overpayment of FFP to these facilities. CDHS took immediate corrective action to rectify this error. As result of the corrective action, all five hospital facilities have reimbursed the overpayment and the FFP was paid back to CMS.

CMS Findings 2: The State made payments to 70 facilities under the O/P program, some of which may not be governmentally operated.

The CDHS disagrees with this finding. Supplemental payments were made to the participating facilities based on the requirements outlined in the State Plan Amendment (SPA) 02-018, Supplemental Reimbursement program for Public Outpatient Hospital Services. SPA 02-018 defines an eligible hospital as the following:

- Provides services to Medi-Cal beneficiaries
- Is an acute care hospital providing outpatient hospital services
- Is owned by a city, county, city and county, the University of California, or health care district

The audit findings specifically listed 15 facilities as having an Internal Revenue Service classification that places their governmental status in question. CDHS has collected these 15 identified facilities' supporting documentation which establishes

their governmental operated status. In accordance with the SPA's definition of an eligible participating hospital, CDHS believes the facilities met these requirements. These documents are available to the audit staff for verification.

CMS Findings 3: The State must expand its efforts in determining the governmentally operated status of facilities involved in the CPE process for purposes of outpatient hospital supplemental payments.

The CDHS agrees with this finding. Previously, in the period of the CMS audit, the State's efforts in determining the governmentally operating status of facilities participating in the program, is based on a self-reported eligibility list from the hospital associations. CDHS then verifies the eligibility of each facility based on criteria from Licensing and Certification (L&C). The final eligibility list is then sent to L&C to further review a wide range of standards in determining whether to issue a license to a provider.

CDHS will revise its eligibility process to require eligible facilities to provide evidence of their governmental status. A copy of the governmental status will be maintained in each facility's folder.

The following is in response to CMS's recommendation on the AB 915 Supplemental Reimbursement program:

CMS Recommendation 1: Make adjustments to the overpayment for the hospital facilities.

CDHS agrees with the recommendation to make adjustments to the overpayment for the hospital facilities. To rectify this, CDHS will conduct a full review of each facility to identify entities that may have included inpatient costs in the reimbursement calculation. CDHS staff will then perform reconciliation reviews of actual expenditures and payments and begin the process to recover excess payments and return excess payments to CMS within 60 days after the conclusion of the reviews.

As a result, additional measures will be made to review and identify facilities in subsequent years that have inadvertently reported inpatient costs information in error. Accordingly, action will be taken to correct any overpayments to the facility and refund FFP amounts as a result of the overpayment to these facilities.

CMS Recommendation 2: Review the governmental status of each facility involved in the supplemental outpatient hospital reimbursement program.

CDHS concurs and will continue to comply with the recommendation to review the governmental status of each facility involved in the supplemental outpatient hospital reimbursement program. All eligible facilities were required to submit additional documentation to the CDHS by the end of July 2006. To date, all eligible participating facilities have contacted CDHS regarding the requested information and

CDHS staff is currently in the process of reviewing and re-verifying each facility's status.

CMS recommendation 3: Ensure that criteria used to determine the governmental status of health care providers is consistent with the Social Security Act.

CDHS agrees with the recommendation in regards to ensuring that the criteria used to determine the governmental status of health care providers is consistent with the Social Security Act. To ensure that the criteria used is consistent with the Social Security Act, CDHS will modify its method and criteria by requesting all facilities to provide the following information as evidence to the entities governmental status:

- Articles of Incorporation;
- Certificate from the Secretary of State;
- IRS letter of 501(c)(3) status; or
- Resolution from Board of Supervisors, City or other government entity

This requested information will be used to verify the status of each participating facility claiming a "unit of government" as defined in 42 USC 1396b(w)(7)(G).

The documentation obtained from each participating facility will be maintained on file with CDHS. This additional step will be in addition to the State licensing and certification review process.